FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046086

Facility Name: Havana Health Care Center

Address: 609 N. Harpham (Number) Havana (City) 62644 (Zip Code)

County: Mason

Telephone Number: (309) 543-6121 **Fax #** (309) 543-1233

IDPA ID Number: 371346306008

Date of Initial License for Current Owners: 03/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Christine A. Hanover Telephone Number: (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 03/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) _____

(Firm Name & Address) Altschuler, Melvoin and Glasser LLP
One South Wacker Drive, Suite 800, Chicago, IL 60606

(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	6,120	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	23,868	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	29,988	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,851	1,851	8
9	SNF/PED					9
10	ICF	16,808	4,796		21,604	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,808	4,796	1,851	23,455	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.21%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 03/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,851

Medicare Intermediary AdminiStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 **Report Period Beginning:** 03/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	88,653	8,216		96,869		96,869	21	96,890			1
2	Food Purchase		90,644		90,644		90,644		90,644			2
3	Housekeeping	63,236	8,150		71,386		71,386		71,386			3
4	Laundry	29,075	7,396		36,471		36,471		36,471			4
5	Heat and Other Utilities			57,675	57,675		57,675	385	58,060			5
6	Maintenance	29,193	26,008	13,863	69,064		69,064	471	69,535			6
7	Other (specify):*											7
8	**TOTAL General Services**	210,157	140,414	71,538	422,109		422,109	877	422,986			8
	B. Health Care and Programs											
9	Medical Director			11,100	11,100		11,100		11,100			9
10	Nursing and Medical Records	774,079	43,642	864	818,585		818,585		818,585			10
10a	Therapy	61,287		4,113	65,400		65,400		65,400			10a
11	Activities	26,701	876	1,440	29,017		29,017		29,017			11
12	Social Services	17,079	253	1,440	18,772		18,772	4	18,776			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	879,146	44,771	18,957	942,874		942,874	4	942,878			16
	C. General Administration											
17	Administrative	129,917		1,240	131,157		131,157	(1,240)	129,917			17
18	Directors Fees											18
19	Professional Services			21,997	21,997		21,997	(6,200)	15,797			19
20	Dues, Fees, Subscriptions & Promotion			6,242	6,242		6,242	300	6,542			20
21	Clerical & General Office Expenses	43,396	6,761	12,718	62,875		62,875	9,196	72,071			21
22	Employee Benefits & Payroll Taxes			171,893	171,893		171,893	11,972	183,865			22
23	Inservice Training & Education			2,312	2,312		2,312	42	2,354			23
24	Travel and Seminar			4,908	4,908		4,908	1,254	6,162			24
25	Other Admin. Staff Transportation			972	972		972	1,398	2,370			25
26	Insurance-Prop.Liab.Malpractice			36,582	36,582		36,582	1,735	38,317			26
27	Other (specify):*											27
28	**TOTAL General Administration**	173,313	6,761	258,864	438,938		438,938	18,457	457,395			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,262,616	191,946	349,359	1,803,921		1,803,921	19,338	1,823,259			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Havana Health Care Center #0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			77,936	77,936		77,936	(27,433)	50,503			30
31	Amortization of Pre-Op. & Org											31
32	Interest			134,785	134,785		134,785	921	135,706			32
33	Real Estate Taxes			44,277	44,277		44,277		44,277			33
34	Rent-Facility & Grounds							2,425	2,425			34
35	Rent-Equipment & Vehicles			5,072	5,072		5,072	1,688	6,760			35
36	Other (specify):*											36
37	**TOTAL Ownership**			262,070	262,070		262,070	(22,399)	239,671			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,509	9,077	36,586		36,586		36,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,982	44,982		44,982		44,982			42
43	Other (specify):* Nonallowable costs			28,841	28,841		28,841	(28,841)				43
44	**TOTAL Special Cost Centers**		27,509	82,900	110,409		110,409	(28,841)	81,568			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,262,616	219,455	694,329	2,176,400		2,176,400	(31,902)	2,144,498			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(1,615)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,770)	43		8
9	Non-Straightline Depreciation	(33,157)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(258)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,920)	43		18
19	Entertainment				19
20	Contributions	(4,421)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer	(9,437)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(101)	43		24
25	Fund Raising, Advertising and Promotional	(2,153)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(4,716)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (71,548)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	39,646		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 39,646		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (31,902)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Programs		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Havana Health Care Center

ID# 0046086

Report Period Beginning: 03/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	To Disallow special event costs	$ (3,721)	43	1
2	To Disallow resident flowers	(640)	43	2
3	To offset income against related expenses	(242)	43	3
4	To offset income against related expenses	(113)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,716)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Havana Health Care Center # 0046086 **Report Period Beginning:** 03/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	21	0	0	0	0	0	0	0	0	0	21	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	385	0	0	0	0	0	0	0	0	0	385	5
6	Maintenance	0	471	0	0	0	0	0	0	0	0	0	471	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	877	0	0	0	0	0	0	0	0	0	877	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	4	0	0	0	0	0	0	0	0	0	4	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	4	0	0	0	0	0	0	0	0	0	4	16
	C. General Administration													
17	Administrative	0	(1,240)	0	0	0	0	0	0	0	0	0	(1,240)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,437)	3,237	0	0	0	0	0	0	0	0	0	(6,200)	19
20	Fees, Subscriptions & Promotions	0	300	0	0	0	0	0	0	0	0	0	300	20
21	Clerical & General Office Expenses	(113)	9,309	0	0	0	0	0	0	0	0	0	9,196	21
22	Employee Benefits & Payroll Taxes	0	11,972	0	0	0	0	0	0	0	0	0	11,972	22
23	Inservice Training & Education	0	42	0	0	0	0	0	0	0	0	0	42	23
24	Travel and Seminar	0	1,254	0	0	0	0	0	0	0	0	0	1,254	24
25	Other Admin. Staff Transportation	0	1,398	0	0	0	0	0	0	0	0	0	1,398	25
26	Insurance-Prop.Liab.Malpractice	0	1,735	0	0	0	0	0	0	0	0	0	1,735	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,550)	28,007	0	0	0	0	0	0	0	0	0	18,457	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,550)	28,888	0	0	0	0	0	0	0	0	0	19,338	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Havana Health Care Center # 0046086 **Report Period Beginning:** 03/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(33,157)	0	5,724	0	0	0	0	0	0	0	0	(27,433)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	921	0	0	0	0	0	0	0	0	921	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,425	0	0	0	0	0	0	0	0	2,425	34
35	Rent-Equipment & Vehicles	0	0	1,688	0	0	0	0	0	0	0	0	1,688	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,157)	0	10,758	0	0	0	0	0	0	0	0	(22,399)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(28,841)	0	0	0	0	0	0	0	0	0	0	(28,841)	43
44	**TOTAL Special Cost Centers**	(28,841)	0	0	0	0	0	0	0	0	0	0	(28,841)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(71,548)	28,888	10,758	0	0	0	0	0	0	0	0	(31,902)	45

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	60.00%	See Attached Schedule		See Attached Schedule		
Mark Petersen	40.00%	See Attached Schedule		See Attached Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 21	$ 21	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	385	385	2
3	V	6	Maintenance Supplies		Petersen Health Care Companies	0.00%	471	471	3
4	V	12	Social Services		Petersen Health Care Companies	0.00%	4	4	4
5	V	17	Administrative	1,240	Petersen Health Care Companies	0.00%		(1,240)	5
6	V	19	Professional Services		Petersen Health Care Companies	0.00%	3,237	3,237	6
7	V	20	Fees Subscriptions & Promotions		Petersen Health Care Companies	0.00%	300	300	7
8	V	21	Clerical & General Ofice Exp		Petersen Health Care Companies	0.00%	9,309	9,309	8
9	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	11,972	11,972	9
10	V	23	Inservices Training & Education		Petersen Health Care Companies	0.00%	42	42	10
11	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	1,254	1,254	11
12	V	25	Other Admin. Staff Transport		Petersen Health Care Companies	0.00%	1,398	1,398	12
13	V	26	Insurance-Prop. Liab. Malpractice		Petersen Health Care Companies	0.00%	1,735	1,735	13
14	Total			$ 1,240			$ 30,128	$ * 28,888	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Petersen Health Care Companies	0.00%	$ 5,724	$ 5,724	15
16	V	32	Interest		Petersen Health Care Companies	0.00%	921	921	16
17	V	34	Rent- Facility & Grounds		Petersen Health Care Companies	0.00%	2,425	2,425	17
18	V	35	Rent- Equipment & Vehicles		Petersen Health Care Companies	0.00%	1,688	1,688	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 10,758	$ * 10,758	39

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center
Provider # 0045252
12/31/2001

VII Related Parties-Page 6

Related Nursing Home	City
Robings Manor Nursing Home	Brighton, IL
Countryview Terrace	Louisville, IL
Sunset Manor Nursing Home	Canton, IL
Kewanee Care Home	Kewanee, IL
Arcola Health Care Center	Arcola, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Prairie City Health Care Center	Prairie City, IL

Out of State Nursing Home

Friendly Village	Rhinelander, WI
Horizons Unlimited	Rhinelander, WI
Taylor Park	Rhinelander, WI
Passport	Rhinelander, WI
Meadow Lawn Nursing Center	Davenport, IA
Cumberland Heights-Tomahawk	Tomahawk, WI
Maple Park	Rhinelander, WI

Opportunities Unlimited (Workshop setup, no beds)

Other Related Business Entities

Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping
Petersen Property	Canton, IL Building-Sunset Manor

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	President	Administrative	100.00%	506,580	4	10.48	Salary	$ 59,421	L17, C1	1
2	Mark Petersen	Secretary	Administrative	0.00%	219,772	4	10.48	Salary	25,779	L17, C1	2
3	Todd Petersen	Administration	Administrative	0.00%	63,846	4	10.51	Salary	7,489	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 92,689		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Havana Health Care Center, Inc
Provider # 0045252
12/31/2001

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Prairie City	Arcola Health Care	Kewanee Care Center	Bement Health Care	Country View Terrace	Eastview Terrace	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Total	Havana Care Center	Grand Total
James Petersen	18,494	88,261	68,695	53,064	14,795	52,568	58,818	60,034	91,851	506,580	59,421	566,001
Mark Petersen	8,023	38,291	29,802	23,021	6,419	22,806	25,517	26,045	39,848	219,772	25,779	245,551
Todd Petersen	2,331	11,124	8,658	6,688	1,865	6,625	7,413	7,566	11,576	63,846	7,489	71,335
Total Compensation Received From Other Nursing Homes	28,848	137,676	107,155	82,773	23,079	81,999	91,748	93,645	143,275	790,198	92,689	882,887

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offi or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, Illinois 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	223,416	8	$ 200	$ 0	23,455	$ 21	1
2	5	Utilities	Patient Days	223,416	8	3,666	0	23,455	385	2
3	6	Maintenance Supplies	Patient Days	223,416	8	4,490	0	23,455	471	3
4	12	Social Services	Patient Days	223,416	8	40	0	23,455	4	4
5	19	Professional Services	Patient Days	223,416	8	30,834	0	23,455	3,237	5
6	20	Fees Subscriptions & Promotions	Patient Days	223,416	8	2,859	0	23,455	300	6
7	21	Clerical & General Ofice Exp	Patient Days	223,416	8	88,667	0	23,455	9,309	7
8	22	Employee Benefits	Patient Days	223,416	8	114,040	0	23,455	11,972	8
9	23	Inservices Training & Educatior	Patient Days	223,416	8	402	0	23,455	42	9
10	24	Travel & Seminar	Patient Days	223,416	8	11,946	0	23,455	1,254	10
11	25	Other Admin. Staff Transport	Patient Days	223,416	8	13,319	0	23,455	1,398	11
12	26	Insurance-Prop. Liab. Malpractice	Patient Days	223,416	8	16,524	0	23,455	1,735	12
13	30	Depreciation	Patient Days	223,416	8	54,520	0	23,455	5,724	13
14	32	Interest	Patient Days	223,416	8	8,774	0	23,455	921	14
15	34	Rent- Facility & Grounds	Patient Days	223,416	8	23,100	0	23,455	2,425	15
16	35	Rent- Equipment & Vehicles	Patient Days	223,416	8	16,083	0	23,455	1,688	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 389,464	$		$ 40,886	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Bank		X	Mortgage	$17,600.00	02/28/01	$ 1,717,793	$ 1,667,733	03/01/04	0.0900	$ 121,278	1
2	Bank of Farmington		X	Van	$1,126.00	03/28/01	54,060	43,924	04/27/05	0.0750	2,621	2
3	Bank of Farmington		X	Car	$585.00	05/30/01	14,030	9,938	06/29/03	0.0750	485	3
4												4
5												5
	Working Capital											
6	First Bank		X	Line of credit	Interest	08/30/01	150,000	150,000	08/30/02	0.0600	7,536	6
7	First Bank		X	Line of credit	Interest	02/28/01	100,000	100,000	02/28/02	0.0750	2,438	7
8												8
9	TOTAL Facility Related				$19,311.00		$ 2,035,883	$ 1,971,595			$ 134,358	9
	B. Non-Facility Related*											
10	Amortization of loan costs										427	10
11												11
12												12
13								Allocated from Home Office			921	13
14	TOTAL Non-Facility Related						$	$			$ 1,348	14
15	TOTALS (line 9+line14)						$ 2,035,883	$ 1,971,595			$ 135,706	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report		$ 63,650	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 63,650	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 63,650	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Amt. Paid by prior owners (19,373) TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 44,277	7

Real Estate Tax History

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000	63,650	12

Facility was purchased on 03/01/01, we used the prorated amount for current year, 100% prior year for accrual

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	005-1479000	Facility	$ 63,633.00	$ 63,633.00
2.	005-3910000	Facility	$ 17.00	$ 17.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,650.00	$ 63,650.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [X] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	418,945	2001	$ 200,000	1
2					2
3	TOTALS	418,945		$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2001	1971	$ 1,314,000	$ 26,673	35	$ 18,771	$ (7,902)	$ 18,771	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			2001	22,650	315	20	566	251	566	9
10	Flooring			2001	5,890	6	20	147	141	147	10
11	Landscaping			2001	8,984	449	20	225	(224)	225	11
12	A/C Heating Unit			2001	3,695	528	20	92	(436)	92	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,355,219	$ 27,971		$ 19,801	$ (8,170)	$ 19,801	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	266,279	38,052	19,020	(19,032)	7	19,020	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			5,724	5,724			74
75	TOTALS	$ 266,279	$ 38,052	$ 24,744	$ (13,308)		$ 19,020	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	2001 Dodge Caravan	2001	$ 46,577	$ 9,315	$ 4,658	$ (4,657)	5	$ 4,658	76
77	Facility use	1999 Oldsmobile	2001	12,992	2,599	1,300	(1,299)	5	1,300	77
78										78
79										79
80	TOTALS			$ 59,569	$ 11,914	$ 5,958	$ (5,956)		$ 5,958	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,881,067	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,937	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 50,503	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,434)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 44,779	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				2,425			6
7	TOTAL				$ 2,425 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,760 Description: Copy Machine $ 561 ; Oxygen Conc. $ 4,511 ; Allocated from Home Office $1688
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facilit

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training wa not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income you facility received training aides from other facilities

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the aide is from your facility or is being contracted to be trained i your facility. Drop-out costs can only be for costs incurred by your own aides
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresse of those facilities for which you trained aides

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A, C1	2356 hrs	$ 37,004		$	$	2,356	$ 37,004	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A, C1	1040 hrs	24,283				1,040	24,283	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 61,287		$	$	3,396	$ 61,287	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (31,733)	$ (31,733)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	438,916	438,916	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,458	7,458	6
7	Other Prepaid Expenses	8,785	8,785	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 423,426	$ 423,426	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,355,219	1,355,219	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	325,848	325,848	16
17	Accumulated Depreciation (book methods)	(77,936)	(44,779)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Mortgage Costs	2,135	2,135	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,805,266	$ 1,838,423	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,228,692	$ 2,261,849	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 145,411	$ 145,411	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,049	54,049	30
31	Accrued Taxes Payable (excluding real estate taxes)	75	75	31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,650	63,650	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Insurance	22,251	22,251	36
37	See Schedule 17A	42,383	42,383	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 327,819	$ 327,819	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	303,862	303,862	39
40	Mortgage Payable	1,667,733	1,667,733	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,971,595	$ 1,971,595	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,299,414	$ 2,299,414	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (70,722)	$ (37,565)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,228,692	$ 2,261,849	48

SEE ACCOUNTANTS' COMPILATION REPORT ***(See instructions.)**

Havana Health Care Center
Provider # 0045252
12/31/2001

XV. BALANCE SHEET

Schedule 17A

Due to Prior Owners	$	12,383
Due to Related Party		30,000
Total (agree to Schedule XV, line 37, column 2)		**42383**

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	218,061	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(288,783)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (70,722)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (70,722)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 2,346,412	1
2	Discounts and Allowances for all Level	3,848	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,350,260	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,080	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 43,080	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	242	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 242	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	879	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 879	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,394,461	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	422,109	31
32	Health Care	942,874	32
33	General Administration	438,938	33
	B. Capital Expense		
34	Ownership	262,070	34
	C. Ancillary Expense		
35	Special Cost Centers	65,427	35
36	Provider Participation Fee	44,982	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,176,400	40
41	**Income before Income Taxes (line 30 minus line 40)****	218,061	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 218,061	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity is a cash basis tax payer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Havana Health Care Center
Provider # 0045252
12/31/2001

Schedule 19A

XVII. INCOME STATEMENT (continued)

E. Other Revenue

Vending Machine Income	$	766
Miscellaneous Income		113
Total	**$**	**879**

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,584	1,584	$ 35,946	$ 22.69	1
2	Assistant Director of Nursing	1,733	1,733	34,937	20.16	2
3	Registered Nurses	4,536	4,560	76,962	16.88	3
4	Licensed Practical Nurses	14,012	14,036	207,624	14.79	4
5	Nurse Aides & Orderlies	38,537	38,587	356,872	9.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,396	3,396	61,287	18.05	7
8	Rehab/Therapy Aides	1,201	1,201	19,297	16.07	8
9	Activity Director	1,755	1,755	17,655	10.06	9
10	Activity Assistants	1,431	1,431	9,046	6.32	10
11	Social Service Worker	1,759	1,759	17,079	9.71	11
12	Dietician	182	182	4,400	24.18	12
13	Food Service Supervisor	1,473	1,473	20,158	13.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,186	10,186	64,095	6.29	15
16	Dishwashers					16
17	Maintenance Worker	2,162	2,162	29,193	13.50	17
18	Housekeepers	8,993	8,993	63,236	7.03	18
19	Laundry	4,284	4,305	29,075	6.75	19
20	Administrator	1,709	1,709	44,717	26.17	20
21	Assistant Administrator					21
22	Other Administrative	445	445	85,200	191.46	22
23	Office Manager	1,870	1,870	20,881	11.17	23
24	Clerical	1,287	1,289	22,515	17.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,008	1,008	13,306	13.20	31
32	Other Health C: Care Plan Coord.	1,498	1,498	29,135	19.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	105,041	105,162	$ 1,262,616 *	$ 12.01	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	11,100	L9, C3	36
37	Medical Records Consultant	1 visit	300	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	9 visits	450	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant	134	4,113	L10a, C3	43
44	Activity Consultant	11	1,440	L11, C3	44
45	Social Service Consultant	11	1,440	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	156	$ 18,843		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Havana Health Care Cente # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Petersen	Administrative	100%	$ 59,421
Mark Petersen	Administrative	0%	25,779
Susan Showalter	Administrative	0%	44,717
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 129,917

B. Administrative - Other

Description	Amount
Management Fees (eliminated in Column 7)	$ 1,240
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,240
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Computer	$ 6,246
Prather Consulting	Computer	3,765
Mid American Programming	Computer	1,350
EXP @ Nets	Computer	47
Ginoli & Co.	Accounting	900
Bush, Snyder & Associates	Legal	9,689
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,997

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,334
Unemployment Compensation Insurance	16,777
FICA Taxes	80,582
Employee Health Insurance	44,079
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K	2,236
Employee Relations	4,885
Allocated from Home Office	11,972
TOTAL (agree to Schedule V, line 22, col.8)	$ 183,865

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	643
Health Care Worker Background Check	
(Indicate # of checks performed 11)	132
Various Licenses	590
Illinois Health Care Association	3,973
Miscellaneous Dues	596
Various Subscriptions	108
Allocated from Home Office	300
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,542

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,404
Seminar Expense	504
Allocated from Home Office	1,254
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,162

* Attach copy of IMRF notifications

**See instructions.

Facility Name Havana Health Care Center
PROVIDER # 0045252
Period Ending 12/31/01

Schedule 21C

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	21,997
Home Office Allocation- Computer Services	995
Home Office Allocation- Accounting-AM&G	19
Home Office Allocation- Accounting-Ginol	1,933
Home Office Allocation- Accounting-Brighton	77
Home Office Allocation- Legal-Bush Snyder & Associates	213
Disallow out-of-period legal fees	(803)
Disallow nonallowable legal fees	(8,634)
Total (agree to Schedule V, line 19, column 8)	15,797

See Accountants' Compilation Report

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 03/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **N/A**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **Illinois Health Care Association $ 3,973**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **Yes** If YES, have these cost
been properly adjusted out of the cost report **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year **No** If YES, what is the capacity **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perio **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **378** Line **10**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **No**
If YES, give effective date of leas **N/A**

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
of Public Aid during this cost report period. **44,982**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee **No** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed
the Department of Public Aid, in addition to the daily rate, been properly classifi
in the Ancillary Section of Schedule V **N/A**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **No** Indicate the amount $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **No** If YES, please indicate the amount of income earned from such
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patient **N/A**
d. Have vehicle usage logs been maintained **Adequate logs have been maintained**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use **N/A**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report **N/A**
g. Does the facility transport residents to and from day training **No**
Indicate the amount of income earned from providing suc
transportation during this reporting period $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **N/A** If no, please explain **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **N/A**
Attach invoices and a summary of services for all architect and appraisal fee

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	88,653	8,216	0	96,869	0	96,869	21	96,890
2. Food Purchase	0	90,644	0	90,644	0	90,644	0	90,644
3. Housekeeping	63,236	8,150	0	71,386	0	71,386	0	71,386
4. Laundry	29,075	7,396	0	36,471	0	36,471	0	36,471
5. Heat and Other Utilities	0	0	57,675	57,675	0	57,675	385	58,060
6. Maintenance	29,193	26,008	13,863	69,064	0	69,064	471	69,535
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	210,157	140,414	71,538	422,109	0	422,109	877	422,986
9. Medical Director	0	0	11,100	11,100	0	11,100	0	11,100
10. Nursing & Medical Records	774,079	43,642	864	818,585	0	818,585	0	818,585
10a. Therapy	61,287	0	4,113	65,400	0	65,400	0	65,400
11. Activities	26,701	876	1,440	29,017	0	29,017	0	29,017
12. Social Services	17,079	253	1,440	18,772	0	18,772	4	18,776
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	879,146	44,771	18,957	942,874	0	942,874	4	942,878
17. Administrative	129,917	0	1,240	131,157	0	131,157	-1,240	129,917
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	21,997	21,997	0	21,997	-6,200	15,797
20. Fees, Subscriptions & Promotion	0	0	6,242	6,242	0	6,242	300	6,542
21. Clerical & General Office	43,396	6,761	12,718	62,875	0	62,875	9,196	72,071
22. Employee Benefits & Payroll	0	0	171,893	171,893	0	171,893	11,972	183,865
23. Inservice Training & Education	0	0	2,312	2,312	0	2,312	42	2,354
24. Travel and Seminar	0	0	4,908	4,908	0	4,908	1,254	6,162
25. Other Admin. Staff Trans	0	0	972	972	0	972	1,398	2,370
26. Insurance-Prop.Liab.Malpractice	0	0	36,582	36,582	0	36,582	1,735	38,317
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	173,313	6,761	258,864	438,938	0	438,938	18,457	457,395
29. Total General Administrative	1,262,616	191,946	349,359	1,803,921	0	1,803,921	19,338	1,823,259
30. Depreciation	0	0	77,936	77,936	0	77,936	-27,433	50,503
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	134,785	134,785	0	134,785	921	135,706
33. Real Estate	0	0	44,277	44,277	0	44,277	0	44,277
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,425	2,425
35. Rent - Equipment & Vehicles	0	0	5,072	5,072	0	5,072	1,688	6,760
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	262,070	262,070	0	262,070	-22,399	239,671
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	27,509	9,077	36,586	0	36,586	0	36,586
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	44,982	44,982	0	44,982	0	44,982
43. Other (specify):*	0	0	28,841	28,841	0	28,841	-28,841	0
44. Total Special Cost Ce	0	27,509	82,900	110,409	0	110,409	-28,841	81,568
45. Grand Total	1,262,616	219,455	694,329	2,176,400	0	2,176,400	-31,902	2,144,498

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-31,733	-31,733
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	438,916	438,916
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	7,458	7,458
7. Other Prepaid Expenses	8,785	8,785
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	423,426	423,426
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	200,000	200,000
14. Buildings, at Historical Cost	1,355,219	1,355,219
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	325,848	325,848
17. Accumulated Depreciation (book methods)	-77,936	-44,779
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	2,135	2,135
23. other (specify):	0	0
24. Total Long-Term Assets	1,805,266	1,838,423
25. Total Assets	2,228,692	2,261,849
CURRENT LIABILITIES		
26. Accounts Payable	145,411	145,411
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	54,049	54,049
31. Accrued Taxes Payable	75	75
32. Accrued Real Estate Taxes	63,650	63,650
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	22,251	22,251
37. Other Current Liabilities (specify):	42,383	42,383
38. Total Current Liabilities	327,819	327,819
LONG TERM LIABILITES		
39.Long-Term Notes Payable	303,862	303,862
40.Mortgage Payable	1,667,733	1,667,733
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,971,595	1,971,595
46.Total Liabilities	2,299,414	2,299,414
47.Total Equity	-70,722	-37,565
48.Total Liabilities and Equity	2,228,692	2,261,849

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,346,412
2. Discounts and Allowances for all Levels	3,848
Subtotal - Inpatient Care	2,350,260
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	43,080
7. Oxygen	0
Subtotal - Anciliary Revenue	43,080
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	242
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	242
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	0
27. Other Revenue (specify):	879
28. Other Revenue (specify):	0
Subtotal - Other Revenue	879
30. Total Revenue	2,394,461
31. General Services	422,109
32. Health Care	942,874
33. General Administration	438,938
34. Ownership	262,070
35. Special Cost Centers	65,427
35. Provider Participation Fee	44,982
37. Other	0
40. Total Expenses	2,176,400
41. Income Before Income Taxes	218,061
42. Income Taxes	0
43. Net Income or Loss for the Year	218,061

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Havana Health Care Cer** **02:54 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-31,902	equal to	-31,902	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	135,706	equal to	135,706	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	44,277	equal to	44,277	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	50,503	equal to	50,503	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,425	equal to	2,425	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,760	equal to	6,760	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	61,287	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	65,400	equal to	65,400	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	422,109	equal to	422,109	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	942,874	equal to	942,874	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	438,938	equal to	438,938	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	262,070	equal to	262,070	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	65,427	equal to	65,427	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	44,982	equal to	44,982	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	725,647	equal to	774,079	-48,432	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	61,287	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	26,701	equal to	26,701	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,079	equal to	17,079	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	88,653	equal to	88,653	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	29,193	equal to	29,193	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	63,236	equal to	63,236	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	29,075	equal to	29,075	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	129,917	equal to	129,917	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	43,396	equal to	43,396	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,262,616	equal to	1,262,616	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	11,100	< or = to	11,100	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	750	< or = to	864	-114	O.K.	Pg20 X14..X16+	B. & C.	I7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,440	< or = to	1,440	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,440	< or = to	1,440	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	129,917	equal to	129,917	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	1,240	equal to	1,240	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	21,997	equal to	21,997	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	183,865	equal to	183,865	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,542	equal to	6,542	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,162	equal to	6,162	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	44,982	equal to	44,982	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	11,972	-11,972	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,851	equal to	1,851	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	39,646	equal to	39,646	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,971,595	equal to	1,971,595	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	63,650	equal to	63,650	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	200,000	equal to	200,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,355,219	equal to	1,355,219	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	325,848	equal to	325,848	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	44,779	equal to	44,779	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-70,722	equal to	-70,722	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	218,061	equal to	218,061	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,228,692	equal to	2,228,692	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1